HOME SLEEP TEST ORDER & QUESTIONNAIRE FORM

CPAP EquipSource
SLEEP APNEA SOLUTIONS

Name:		HT/Weight:	DOB:	Gender
Address:	City:		State:	Zip
E-Mail:	Phone:			
Are you currently on BiPAP/CPAP?	**What is the current order?**			

Primary Provider - Physician Information

Name:	Fax:	Phone:	NPI:

Sleep History (fill in blank and check all symptoms that apply)

☐ Sleep Disordered Breathing	☐ Loud Snoring	☐ Depression	☐ Observed Apnea
☐ Oral Appliance Assessment	☐ Non-Restorative Sleep	☐ Gasping/Choking	☐ Dry Mouth
☐ Excessive Daytime Sleepiness	☐ Morning Headaches	☐ Dry Mouth in A.M.	

Past Medical History - Describe in detail your past medical history below.

Please answer the following questions regarding the symptoms you have been experiencing that may indicate signs of sleep apnea;

Do you snore loudly? Yes ____ No _____

Do you feel fatigued during the day? Yes ____ No _____

Do you wake up feeling like you haven't slept? Yes ____ No _____

Have you been told you stop breathing at night? Yes ____ No _____

Do you gasp for air or choke while sleeping? Yes ____ No _____

Do you have high blood pressure? Yes ____ No _____

Are you diabetic? Yes ____ No ____

Is your body mass index greater than 35? Yes ____ No _____

Are you 50 years old or older? Yes ____ No _____

Are you a male with neck circumference greater than 17 inches? Yes ____ No _____

Are you a female with a neck circumference greater than 16 inches? Yes ____ No _____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze
1 = Slight change of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Sitting and reading	____ 0 ____ 1 ____ 2 ____ 3
Watching TV	____ 0 ____ 1 ____ 2 ____ 3
Sitting in a car as a passenger for a continuous hour	____ 0 ____ 1 ____ 2 ____ 3
Lying down to rest in the afternoon when circumstances permit	____ 0 ____ 1 ____ 2 ____ 3
Sitting and talking to someone	____ 0 ____ 1 ____ 2 ____ 3
Sitting quietly after a lunch without alcohol	____ 0 ____ 1 ____ 2 ____ 3
Sitting in a car stopped in traffic for a few minutes	____ 0 ____ 1 ____ 2 ____ 3

TOTAL SCORE: 0-9 Normal Range 10-11 Borderline 12-24 Sleepy

SLEEP TESTING DEVICE INFORMATION

1 or 2 night unattended, type III Portable recording with minimum four (4) channels: Records airflow, respiratory effort, 02 saturation and heart rate performed on room air unless specified below.

TEST TO BE PERFORMED UNDER THE FOLLOWING CONDITIONS;

☐ Test on Room Air – check here if test is to be performed without oxygen and on room air.
☐ Test on Oxygen – check here if test is to be performed with patient on oxygen.
☐ What are the current oxygen orders? _____ Continuous or PRN?_____

Patients with continuous oxygen orders or who require supplemental oxygen at night will remain on oxygen therapy during the sleep test. Patient will wear the oxygen nasal cannula and flow sensor cannula from the ApneaLink device for the test. The oxygen liter flow will need to be titrated to maintain an oxygen saturation of 90% at all times during the HST. Apply the lowest amount of oxygen flow as to not exceed an SpO2 of 90%. Failure to maintain the patients SpO2 at 90% will underscore and mask the severity of the residents OSA if present.

Sleep Testing Equipment Loan Agreement

This agreement is between the Facility and CPAP EquipSource.

Terms and Conditions of Equipment Loan

1. CPAP EquipSource will lend the ***ResMed ApneaLink*** home sleep apnea testing monitor to the customer on the terms and conditions of this agreement.
2. The equipment shall be loaned from delivery date until test completion date.
3. The equipment loan period may be extended by mutual consent of both parties
4. No variation or amendment of this agreement will be effective unless it is made in writing and approved by the General Manager.

Collection and Delivery of Equipment

CPAP Equipsource will send via UPS or customer will pickup from our retail store the device to be used for the Home Sleep Test.

Title and Risk

1. Title and all rights to the equipment shall at all times remain with CPAP EquipSource. The patient and facility acknowledge that it has no right, title or property in the equipment.
2. Medicina will have the equipment checked to ensure it is fit for purpose prior to collection.
3. Risk of any loss or damage to the equipment will become the responsibility of the facility upon receipt of the device and shall not revert back to Medicina until the equipment is returned back to CPAP EquipSource in good working order.

Cleanliness

The equipment will be appropriately cleaned prior to the loan period by CPAP EquipSource staff.

Requestor Obligations

1. Provide the patient with operating and training instructions as appropriate.
2. Provide the necessary additional information (printed material) about the correct use of the equipment and customer support.

The FACILITY undertakings/responsibilities

The customer borrowing the equipment agrees that during the loan period it shall:

1. Keep the equipment in its possession and control and ensure that it is secure against loss, damage and theft.
2. Operate the equipment in accordance with any operating instructions issued for it and for the purpose it was designed.
3. Keep the equipment in good working order.
4. Notify CPAP EquipSource that test has been completed. Call customer service at 1-440-625-0660.

Lost or Damaged Equipment

In the event of the equipment being lost or damaged the facility agrees to pay the replacement cost ($2,400.00) to CPAP EquipSource.

Facility Authorized Employee Name: _____

Signature: _____

Date: _____

CPAP EquipSource
7580 Pearl Road
Middleburg Hts, Ohio 44130
Phone: 1-440-625-0660
FAX: 1-866-763-9505
orders@cpap411.com
www.cpap411.com